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by John P. Benson, JD, AHFL, CFE

COMPLIANCE 101

Telemedicine, Part 1: The origin and drivers of telehealth care

- » Patients who live in rural and remote areas are well served by telemedicine.
- » Telemedicine decreases visits to and shortens stays at hospital facilities.
- » Specialized provider skills serve a broader population.
- » The economics of telemedicine are favorable as technology costs decrease.
- » Telemedicine shows promising outcomes in treating chronic disease.

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Telemedicine combined with telehealth, serve myriad purposes that can be divided into two sections: improved patient outcomes and lowering federal healthcare spending. One, patients receive care from and exposure to resources to which they ordinarily would not have access. And two, healthcare facilities and, most pointedly, Emergency Rooms see fewer visits, thereby mitigating waits, overcrowding, and the risk of exceeding visit limits.

There are distinctions between the two terms in use. Telehealth extends into the self-accountability model through education and prevention as well as practitioner continuing education. Telemedicine stops at diagnosis and treatment through electronic means.

Timeline of telemedicine serving patients

The imaginings of electronic telemedicine were documented as early as 1924 on the cover of *Radio News*, which showed a rendering of a patient viewing a transmitted image of his doctor on a television-like contraption. Documented use of telemedicine is first cited in 1950 where radiology images were transmitted a distance of 24 miles by telephone.^{1,2}



Benson

From there, the concept developed to treat mental health through video diagnosis and therapy sessions, speech therapy, consultations, patient monitoring, education, research, and much more. In addition to the real-time clinical applications, telemedicine includes sending data, such as electrocardiograms, x-rays, and sonograms.

People in need of medical help have been using telemedicine since the invention of the telephone, with everything from

calling 9-1-1 to calling a nurse to discuss test results. Telemedicine offers an indisputable value to patients and continues to build out service offerings with virtual reality technology and cloud-based information sharing.

Motive for a new paradigm

In addition to the obvious solution of being able to enhance a patient's treatment options by creating remote access to primary and allied health practitioners and a wide variety of specialties and sub-specialties, telehealth provides efficiencies around scale, throughput, and distribution—all of which can drive down cost and improve long-term outcomes. These reasons support the motive to gravitate toward the new paradigm of virtual healthcare.

One phenomenon driving a new paradigm for healthcare is that the smallest ratio of a population accounts for the highest ratio of healthcare spending. Another driver is the growing aging population coinciding with a declining practitioner population.

In 2009, a healthcare spending survey found that 1% of healthcare recipients accounted for 20% of healthcare spending.³ That set falls in the top 5% of healthcare recipients who account for just less than half of all spending. The lopsided ratio is only accelerating as the largest segment of the population moves to the age of Medicare entitlement.

In 2016, a National Institute for Health Care Management (NIHCM) Foundation study found that Medicare accounts for 15.2% of federal spending and Medicaid,

CHIP, and ACA subsidies account for 11.1%.⁴ According to the NIHCM study, together they represent 26.3% of the federal budget being spent on healthcare. The Medicare portion of the budget is projected to continue to increase at a rate of 7.3% per year as the last of the Baby Boomer population reaches retirement age in 2032.⁵

The Department of Veterans Affairs (VA) published evidence that telehealth

lowers the cost of healthcare and has high rates of patient satisfaction.⁶ According to the VA, in the numbers from documentation in 2012, remote healthcare reduced bed days of care by 53%, hospital

admissions by 30% and bed days of care for mental health patients by 28%. The VA noted that patient satisfaction ranked around 90%. In addition, the VA found that savings on travel is around \$35 per consultation with a calculated savings of \$1,999 per annum per patient. The VA provided telecare from 150 VA medical centers and 750 community-based outpatient clinics to 485,163 patients, amounting to 1,380,431 telehealth consultations in 2012.

Healthcare spending and reform

From the evidence being collected over the past several years, telemedicine/telehealth as a portion of continued healthcare reform, is a tactical defense mechanism against the perpetual deficit created by exponentially increasing Medicare expenditures.

Telemedicine offers up categorical solutions to the skewed amount of healthcare spending on a small percent of the population. In many cases, it is age and chronic

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conditions that dictate an increased amount of spending. According to a NIHCM Foundation Data Brief, the top three chronic conditions contributing to high spending in those aged 65+ are essential hypertension (high blood pressure), lipid metabolism disorder (cholesterol), and diabetes.⁷ In addition, the Data Brief found that the top three chronic conditions contributing to high spending for those less than 65 years of age are essential hypertension, mood disorders, and lipid metabolism disorder.

Patients with hypertension have the potential for better long-term outcomes and quality of life through telemedicine. The biggest hurdle is patient engagement, breaking the habits of onsite visits, and replacing behaviors with adopting telehealth protocols that could include receiving text messages that remind patients to send in results from blood pressure readings as well as e-visits that can flesh out the balance of critical information not provided by template-style data collection processes.

Home blood pressure telemonitoring (HBPT) is beginning to show measurable positive outcomes over traditional care.⁸ Cost of equipment, however, counteracts the lowered healthcare costs at the moment. But as in all technology, costs are expected to drop, eventually having an economic effect that matches the promising outcomes.

Chronic conditions, such as high blood pressure and cholesterol, are primarily managed through the consistent ingestion of medication with regular monitoring, and most of the expense reported is the cost of medication. But when a chronic condition is

also critical, blood pressure can be continuously measured and reported via wireless sensors that can use electronic dispatch. For high-risk individuals who suffer from heart disease, wireless heart monitoring devices cut down on hospital visits with real-time notifications. This also cuts down the time a physician takes to review charts by providing a visual presentation of the data and built-in analytics.⁹

Sleep apnea is one of the unique conditions where telemedicine can re-design the entire diagnosis, monitoring, and treatment through remote systems that allow the patient to stay at home for the many tests that typically take place in a clinic or hospital.

As the health-care industry shifts from fee-for-service to outcome-based reimbursement, not only will practitioners and facilities use the monitoring data germane to the nature of telemedicine, the

Sleep apnea is one of the unique conditions where telemedicine can re-design the entire diagnosis, monitoring, and treatment through remote systems...

patient population will be informed and guided by outcome-driven data. Because the progressive notion of healthcare is self-care, the frequent digital access to self data, as well as to providers, empowers the patient to be knowledgeable and proactive.

Providers that offer telemedicine services have an opportunity to serve patients in outlying rural areas as well as urban areas distant from specialized care. This ups the patient's probability for better health outlook and quality of life in rare, esoteric conditions not treatable by the community generalist physician and also increases a provider's quantity of outcome studies.

Globally, the outcome-driven, expanded-provider options paradigm transitions the patient towards consumer-empowered thinking and decision making. In addition, the corroboration of collective outcome data will accelerate a culture of patient-focused care—optimal positioning for the future of the US healthcare system.

Now that telemedicine is hitting critical mass, wide adoption will call into play issues of licensure, credentialing, privileging, and compliance challenges, especially with regard to HIPAA.

For hospitals, clinics, and practices that want a piece of the telemedicine pie, the walk-before-you-run approach is to offer tele-services in-state, eliminating the licensure hurdle while matching ambition with reality. The next stage is to identify one particular patient type, design a model, invest in appropriate technology (or vendor), and continuously measure in order to perfect the levels of patient interface, the protocols,

and the technology in order to improve the probability of an increased level of outcomes. Most importantly, providers can share their trials, lessons, and successes for a collective positive effect on the evolution of healthcare. ☺

Part 2 of the Telemedicine series, in an upcoming issue of Compliance Today, will cover the topics of licensure, credentialing, privileging, and compliance.

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Compliance 101, Fourth Edition

Authors Debbie Troklus and Sheryl Vacca have updated Compliance 101 with changes in federal regulations, including HIPAA, HITECH, and the Omnibus Rule as well as new insights on what it takes to build an effective compliance program. This book reviews the fundamentals in healthcare compliance, including the seven essential elements of a compliance program. It includes:

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- **A glossary with compliance terms and definitions**
- **Sample compliance forms and policies**

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